



 Idaho Physical Medicine & Rehabilitation

NEW PATIENT QUESTIONNAIRE

Please sign **EACH** page of this form.

DATE: _____

NAME: _____ AGE: _____ M/F

CHIEF COMPLAINT: _____

WHO REFERRED YOU? _____

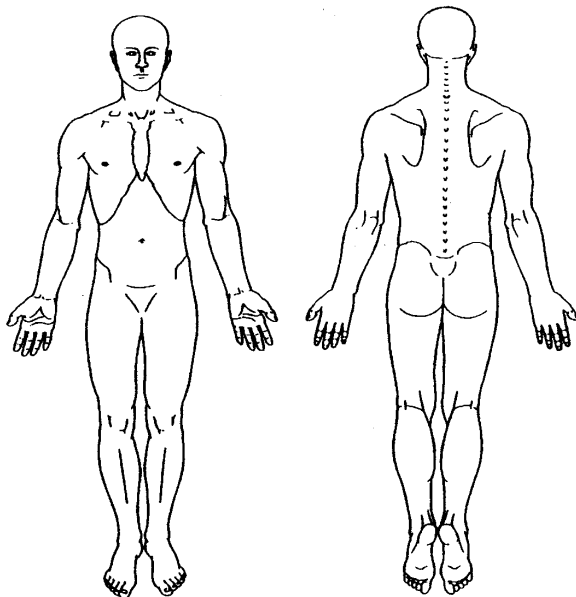
Where is your pain? Please mark on the drawing where you feel pain right now. Use the key below to indicate where and what type of pain.

Pins & Needles = 000

Stabbing = ///

Burning =XXX

Deep Aches = ZZZ



RATE YOUR PAIN (Please circle your rating)

0 = No Pain

10 = Extreme Pain

- 1. Right now: 0 1 2 3 4 5 6 7 8 9 10
- 2. At best: 0 1 2 3 4 5 6 7 8 9 10
- 3. At worst: 0 1 2 3 4 5 6 7 8 9 10

4. What makes it better? _____

5. What makes it worse? _____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS OR TREATMENTS FOR THIS PROBLEM?

<u>TESTS:</u>	<u>YES</u>	<u>NO</u>	<u>DATE</u>
X-Rays	_____	_____	_____
MRI	_____	_____	_____
CT Scan	_____	_____	_____
Myelogram	_____	_____	_____
Bone Scan	_____	_____	_____
EMG	_____	_____	_____

<u>TREATMENTS:</u>	<u>YES</u>	<u>NO</u>	<u>DATE</u>
Medication	_____	_____	_____
Injections	_____	_____	_____
Surgery	_____	_____	_____
Physical Therapy	_____	_____	_____

Other Tests or Treatments: _____

PAST MEDICAL HISTORY:

List Medical Problems: _____

List Surgeries & Dates: _____

List Current Medications: _____

List Any Medication *Allergies*: _____

List Medical Problems that Run in Your Family.

Mother _____ Father _____ Siblings _____

Do you smoke or use tobacco products? (Please Circle) YES NO
If YES, how much/many per day? _____

Do you drink alcohol (beer, wine, etc.)? (Please Circle) YES NO
If YES, frequency/amount per day? _____

Are you or have you in the past used street drugs or been addicted to drugs? YES NO

Please Explain: _____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____

REVIEW OF SYSTEMS *Circle any of the following that apply to you and write comments as necessary:*

- Constitutional:** Fevers, chills, sweating, weight loss, and weight gain
- Eyes:** Blurred vision, blind spots, eye pain, double vision
- Ears, Nose, Throat:** Ear pain, decreased hearing, decreased balance, dizziness, respiratory infection, sore throat, hoarse voice, chronic sinusitis, problems with teeth and gums
- Cardiovascular:** Chest pain, shortness of breath with exertion, irregular heart beats, prior heart attack
- Respiratory:** Cough, shortness of breath, painful breathing, coughing up blood, pneumonia, bronchitis, asthma, emphysema, TB
- Gastrointestinal:** Indigestion, nausea, abdominal pain, jaundice, poor appetite, diarrhea, constipation, loose stools, loss of bowel control, ulcer, hiatal hernia, black stools
- Genitourinary:** Difficulty urinating, loss of bladder control, painful urination, sexual problems, kidney stone, abnormal vaginal discharge, pregnant
- Musculoskeletal:** Falls, new injury, joint pain, muscle pain, joint swelling, decreased ability to perform daily activities, difficulty walking, swelling arms/legs, trembling/shaking
- Skin:** Rash, skin sores, skin swelling or redness, breast lump, breast discharge
- Neurological:** Stroke, new numbness, new weakness, headache, poor balance, dizziness, decreased hearing, seizure, forgetfulness
- Psychiatric:** Anxiety, depression, anger, difficulty sleeping, low energy, thoughts of suicide, suicide attempt
- Endocrine:** Sweating, increased fatigue, frequent urination, blood sugar problems, menstrual problems, weight loss, weight gain, thyroid problems, Swollen glands
- Hematological:** Unusual bleeding, new lump, nosebleeds, blood clots
- Allergic:** New drug reaction or allergy, hay fever, hives, wheezing
- Infection:** HIV, AIDS, Hepatitis, Other _____

Patient Signature: _____ Date: _____

Reviewed by Physician: _____ Date: _____